

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11257

State File No. _____

Registrar's No. 34

FILED AND 23 1940 4.4
Registration District No. 1-1-1

Primary Registration District No. 5-5-8

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural - Washington Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Kansas City Convalescent Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 Days
(Specify whether
In this community 33 Years
years, months or days)

3. (a) PRINT FULL NAME Smiley R. Westrope

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 26 1868
(Month) (Day) (Year)

8. AGE: Years 71 Months 6 Days 14 If less than one day _____ hr. _____ min.

9. Birthplace Scottville Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Labor - Retired 15 Yrs.

11. Industry or business Ford Motor Co.

12. Name John Travis Westrope

13. Birthplace Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Mary Bellard

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Elvis T. Westrope

(b) Address 708 W. 48th

17. (a) Burial (b) Date thereof March 12 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hill Cem.

18. (a) Signature of funeral director J. Dale Walter

(b) Address 7406 W. 11th Rd.

19. (a) 4-9-40 (b) Mrs. J. O. Brennan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 708 W. 48th
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10th
year 1940 hour _____ minute _____ A.M.

21. I hereby certify that I attended the deceased from March 8
1940, to March 10 1940
that I last saw him alive on March 10 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Labor Pneumonia Duration about 50 days

Due to injury

Due to dehydration

Other conditions 10 days
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature De H. W. yatt (M. D. or _____)

Address 3850 Promet Date signed 3-11-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Harley Roe

Licensed Embalmer No. *7810*

P. O. Address *7406 Central*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.